A SUCCESSFUL CASE OF CHOLECYSTOTOMY FOR THE REMOVAL OF GALL-STONES OBSTRUCTING THE CYSTIC DUCT.

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A Successful Case of Cholecystotomy for the Removal of Gall-Stones obstructing the Cystic Duct.

THE patient, Mrs. M. J. W., was sent to me on November 17, 1891, by her physician, Dr. Robert G. Barckley, of Honesdale, Pa., with the following history: She was 36 years of age, and the mother of eight children. Her health had always been good up to three years ago, when she was seized with an attack of biliary colic, lasting for three hours. Subsequently she had a number of these attacks, with an interval generally between them of from two to three months. Lately, however, the interval has been only three weeks. The attacks were characterized by intense pain in the hypochondriac and epigastric regions, associated with persistent vomiting. In May, 1891, the patient passed seven gall-stones. The stones were mulberry-shaped and about one-sixteenth of an inch in diameter.

When I first saw the patient her general condition was fair, and there was no indication of jaundice present. The hepatic region was tender to the touch, but there was no enlargement either of the liver or of the gall-bladder demonstrable.

Operation.—Cholecystotomy was performed at the Polyclinic Hospital on November 19, 1891, Dr. Barckley, of Honesdale, and Dr. John H. Gibbon, senior resident of the hospital, assisting at the operation. The abdominal cavity was opened by a vertical incision, beginning just below the tip of the cartilage of the ninth rib and extending downward for a distance of three inches. As soon as the peritoneal cavity had been opened, the gall-bladder came into view. It was somewhat distended, and its walls greatly thickened, due probably to a subacute cellulitis of the external coats. At first no stone could be felt through the bladder-wall, but a more careful search revealed the presence of a small, hard, round mass in the region of the commencement of the cystic duct. After packing gauze-pads beneath and around the gall-bladder, an incision was made through the fundus. Upon introducing the index-finger through this opening, a stone was felt, obstructing the entrance to the cystic duct. As it was impossible to remove the calculus with the finger, a spoon-scoop was used to dislodge it, when a second stone was discovered immediately below the first. This was then removed with the spoon-scoop, assisted by external pressure with the fingers. As a careful examination failed to show the presence of a stone in the common duct, the operation was completed by stitching the opening into the bladder to the abdominal incision and inserting a rubber drainage-tube. Irrigation or drainage of the peritoneal cavity was not employed.

After-History.—The patient made a rapid

recovery, and she was discharged from the hospital on December 15, 1891. The operation, which was completed in thirty minutes, was not followed by shock. The pulse immediately after the section was 70 per minute, and the highest number of beats reached during convalescence was only 90. Up to the sixth day the temperature varied from 98.4° to 100.4°, when it became normal, and remained so without any subsequent rise. The administration of calomel was begun twenty-four hours after the operation, and was followed next morning by a stimulating rectal injection. No movement of the bowel occurred, however, until several doses—five grains each of ox-gall—had been given. The rubber tube was removed from the bladder on the ninth day, and in it was found a small gall-stone. At the time the patient left the hospital the biliary fistula had not closed. A recent report from the patient (April 10, 1892) stated that the fistula still remained, but that there had been no return of the biliary colic, and that her general condition was good.

Remarks.—The abdominal incision in this case was made directly over the position of the gall-bladder, taking the tip of the cartilage of the ninth rib as the landmark. This is probably the best situation for the opening through the belly-wall, except in those cases in which the gall-bladder is distended, and forms a distinct tumor, when the incision should be made directly over its most prominent portion.

The method of opening the gall-bladder is of importance, and depends upon whether it is greatly distended or not. In the former

case a small trocar should be employed, and the bile carefully drawn off. If, however, the distention is not great, the best plan is to grasp the fundus of the gall-bladder between the thumb and index-finger, and make an incision between them directly into the organ with the point of a knife. This is the method which is employed in opening the intestine in making an anastomosis, and it has the great advantage of not injuring the walls of the gall-bladder, as would be the case if a forceps is employed to raise and steady the line of incision. Before opening the bladder, care should be taken to prevent the bile from escaping into the peritoneal cavity. For this purpose nothing is better than gauze-pads placed beneath and around the seat of operation. By this means the peritoneum will be thoroughly protected, and any overflow of bile into the abdominal cavity prevented. As an additional precaution against the escape of bile into the cavity of the abdomen, the fundus of the gall-bladder should be drawn over the edge of the parietal incision prior to making the opening, so that when the bladder is opened the biliary secretions will flow over the abdominal wall and away from the seat of operation.

The long continuance of the biliary fistula in this patient indicates an obstruction at some part of the common duct, and therefore any attempt to close the opening by freshening its edges would result in failure. Should the fistula continue to remain open, and the patient returns to have it closed, I shall operate in the following manner: 1. Open the abdominal cavity just below the fistula. 2. Make a

communication between the upper portion of the jejunum and the gall-bladder, using solid rubber rings, threaded with catgut instead of silk, to hold the opposing surfaces together. The ring, which is placed in the gall-bladder, should have a long silk thread attached to each segment, and brought out through the fistula. At the end of a week or ten days, when the ring in the bowel has become separated, traction is made upon the threads, and the ring in the gall-bladder is brought up to the fistulous opening and removed. 3. Freshen the edges of the biliary fistula, and bring them together with sutures, and thus close the opening. Were a similar case of cholecystotomy to present itself,—that is, one in which the gall-bladder was not too contracted, or its walls perforated from ulceration, or its position abnormal,—I would be inclined to do at once an entero-cholecystotomy, instead of completing the operation by stitching the fundus of the bladder to the abdominal incision. This would do away with the great annoyance of a biliary fistula, and would add, I believe, but little to the danger of the operation.

A point of some practical interest in the after-history of this case was the prompt action of the ox-gall in removing the constipation which followed the operation.

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